Veterans' Mental Health in the Wake of War

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Some aspects of the psychological experiences of war bind veterans together across temporal and national boundaries. Consider Hotspur's traumatic nightmares in Shakespeare's *King Henry IV, Part I*, the challenges confronting Homer's Odysseus on his return home from Troy, the alienation and reentry problems faced by the German survivors of the trenches of World War I in Erich Maria Remarque's *The Road Back*, and the emotional numbing and intrusive recollections of jungle warfare afflicting Bao Ninh's North Vietnamese protagonist in *The Sorrow of War*. These depictions continue to ring true with regard to our newest veterans from Afghanistan and Iraq.

I began to appreciate the powerful bond that unites veterans with their living and dead brothers and sisters during a 1990 visit to the former Soviet Union, when I met young Soviet veterans ("Afghantzi") who had recently been defeated by the mujahideen in the treacherous terrain of Central Asia. These fighters were the same age as the Vietnam veterans were when I first began to see them in the early 1970s; they were clean-shaven with crew cuts, in contrast to my very hairy clientele of years ago; and they were more likely to reach for vodka than marijuana in a futile effort to suppress intolerable war-related memories and feelings. Nevertheless, these hollow-eyed Afghantzi transported me back to the time when young U.S. veterans began to flood Veterans Administration (VA) hospitals, demanding that we do something to alleviate their angst and despair. Like those veterans, the Afghantzi were agitated, depressed, guilt-ridden, suicidal, mistrustful, enraged, emotionally anesthetized, and bombarded, day and night, by vivid, unbearable memories of war.

Although most returnees from Iraq and Afghanistan will not have any lasting mental health problems, a substantial number of them will exhibit clinically significant symptoms and disabilities. We must prepare for the challenges, some timeless and others new, presented by these veterans of our most recent wars.

In the United States, we have learned much from veterans of the Vietnam War. As a society, we have learned not to confuse the war with the warrior. Antiwar activists opposed to the political decisions that result in military operations no longer vent their rage against the brave, and sometimes shattered, men and women who have risked their lives

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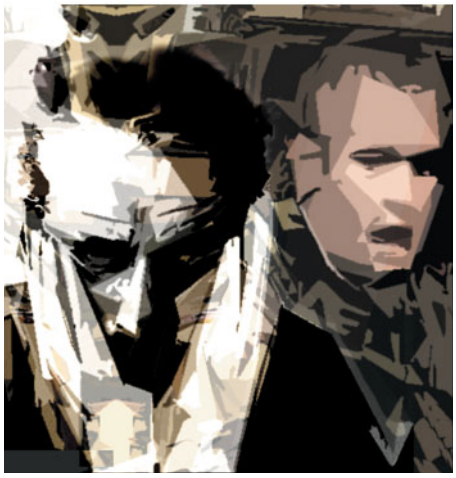
while obeying orders. This change represents a quantum leap from the 1970s, when courageous Vietnam veterans, greeted at the airport by hostile demonstrators, became enraged at and alienated from an American public that showed no interest in understanding how their war experiences had changed their lives. We have learned that the homecoming decisively affects veterans' readjustment to civilian life. Public antagonism or indifference can spawn alienation and distrust and promote the development of post-traumatic stress disorder (PTSD) and other psychiatric problems.[1]



The mental health system in the United States has moved well beyond the official ignorance that prevailed in the 1970s and now recognizes PTSD as a diagnosable disorder. Armed with this diagnosis and prodded by veterans, rape victims, and survivors of genocide, we have begun to appreciate the profound and sometimes irreversible changes produced by overwhelming stress. These include fundamental alterations in perception, cognition, behavior, emotional reactivity, brain function, personal identity, worldview, and spiritual beliefs.

Moreover, new treatments have changed the landscape of hope. When the first Vietnam veterans arrived on the doorsteps of VA hospitals 30 years ago, we didn't know what to do for them. We now have evidence-based psychosocial and pharmacologic approaches that have met rigorous scientific criteria for effectiveness. Relevant practice guidelines have been developed by a joint task force of the VA (now the Department of Veterans Affairs) and the Department of Defense, the American Psychiatric Association, and the International Society for Traumatic Stress Studies. Although we continue to test new approaches, we currently have effective clinical tools that can ameliorate psychological distress and — sometimes — eliminate PTSD.

Fortified by such progress, however, we must prepare for some unprecedented challenges presented by our newest veterans. These include the stigma against disclosing psychiatric difficulties to military mental health professionals, the problems unique to National Guard and Reserve troops, the effects of sexual assault occurring within a military unit, and the uncertainties of life after discharge for the remarkably large number of amputees and other wounded combatants.

Years ago, VA practitioners who were seeing traumatized veterans 10 to 20 years after their war experiences did not worry, as we do today, that the stigma attached to mental illness might either prevent public disclosure of symptoms of PTSD or suppress treatment-seeking behavior.[2] One possible explanation is that Vietnam veterans had already been stigmatized in the eyes of the American public; paradoxically, such widespread prejudice may have fostered a sense of solidarity among affected veterans, who began to see PTSD as a badge of honor, a psychological Purple Heart, around which all could rally. Indeed, without the solid public support of the Vietnam veterans' community for clinicians and researchers working on PTSD, many advances in science and treatment might never have been achieved.

Another possible explanation is that returning troops now perceive a great difference between disclosing PTSD symptoms to VA clinicians and disclosing them to military mental health professionals. Whereas there is still little stigma associated with such a disclosure within VA settings, there are perceived risks within the military setting — and a resultant reluctance to seek treatment. Yet times have changed dramatically since the post-Vietnam era, and military clinicians are eager to assist uniformed personnel whose functional capacity is affected by PTSD. All troops currently receive health assessments before and after deployment to facilitate the early identification and treatment of PTSD. Furthermore, this past January military mental health policy was modified with the addition of a third health assessment three to six months after troops return from Iraq. Although the battle against this stigma is far from over, it is encouraging that the Pentagon recognizes its importance.

Members of the National Guard and military reservists constitute a large proportion of the persons deployed in Iraq. Unlike their active-duty counterparts, they are civilians who are not steeped in military culture, do not live on military bases, did

not volunteer for full-time service, and had not expected to be tapped for protracted and dangerous duty in a war zone. In addition to causing adverse reactions to the traumatic stress of war, deployment can disrupt marriages and family and work life, sometimes with serious consequences. Such disruption may partially explain why National Guard and Reserve personnel involved in the Gulf War exhibited more postdeployment psychiatric problems than did active-duty troops.[3] Mental health services must be accessible for this population.

Sexual trauma is a serious problem for women and men serving in current deployments. Sexual assault within a military unit can lead to a heightened sense of apprehension and vulnerability, because victims must continue to live and work closely with the perpetrators. Furthermore, victims are often silenced by peer pressure, unreceptive leaders, or the fear of jeopardizing their careers. This problem can be resolved only if safety and confidentiality can be ensured for victims who wish to disclose such events and if treatment can be provided to ameliorate adverse psychological effects.

An unprecedented number of the wounded — 90 percent — are now surviving their injuries.[4] Although amputations have received the most attention, other injuries also have long-lasting effects on veterans' quality of life, marital adjustment, vocational opportunities, self-image, outlook with regard to the future, and mental health. Indeed, veterans with war injuries rank among those at highest risk for PTSD.[5] Awareness of this risk should guide mental health policy and practice from the time of medical evacuation through follow-up care.

Despite these important departures from previous conflicts, the psychiatric consequences for our newest veterans will have much in common with the psychological anguish of their predecessors. We must be ready for these veterans. We must learn from past mistakes and make good use of our new clinical and conceptual tools. Our veterans deserve nothing less.

Dr. Friedman reports having served as a paid speaker for GlaxoSmithKline, Ortho-McNeil, and AstraZeneca.The opinions expressed in this article are those of the author and do not necessarily reflect the views of the Department of Veterans Affairs.

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